FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

KURL B. KURTZ
Idaho Department of Health & Welfare

SCHIP Program Name (s) CHIP

SCHIP Program Type ____Medicaid SCHIP Expansion Only
____Separate SCHIP Program Only
____Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility NC

2. Enrollment process

Mail in applications are accepted as part of the Departments efforts to remove a significant barrier for parents, especially working parents, in accessing Children's Health Insurance for their children. This approach eliminated the need for parents to take off time from work in order to attend a face-to-face interview. It also was designed to encourage parents to apply who might otherwise have been reluctant to come into the Health and Welfare office because of the perceived stigma of "Medicaid."

3. Presumptive eligibility NC

4. Continuous eligibility

Establishment of a 12-month continuous eligibility period for children was implemented 11/99. This change was made:

- To increase the retention rate for children enrolled in the Children's Health Insurance Program.
- To simplify administration of the program.
- To allow for continuity in health planning and care for participants and providers.

5. Outreach/marketing campaigns

The following changes to Idaho's outreach plan have been implemented since September 30, 1999. In addition to the information below, see Attachment 1. Idaho views outreach to families of children likely to be eligible for assistance as a two-pronged process of outreach and education. These activities are defined as follows:

> **Outreach:** Activities targeted toward informing and motivating potentially eligible families to apply for health care coverage.
>
> **Education:** The process of giving individuals and organizations who come into contact with low-income children information on health care coverage options.

Outreach and education activities are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. Outreach activities are associated with a set of complex procedures in which families interact with state and local government agencies, advocacy groups, and other organization involved in outreach (Halfon, et al, Milbank Quarterly, 1999, p. 189). In other words, Idaho does not view quality outreach as synonymous with public relations. General media activities are an important component of a quality outreach plan but media is certainly not the only component and depending on the population to be reached may not be the most effective component.

Halfon, et al, have identified a number of critical factors leading to successful outreach. These factors are:

- Targeting
- Appropriate Message and Type for Targeted Group(s)
- Location of Outreach Activities for Targeted Group(s)
- Appropriate Media and type for Targeted Group(s)
- Cultural/Language Considerations for Targeted Groups(s)

DHW has determined that to reach the target group families, education should be directed to the following groups:

- Schools
- Culturally Diverse Groups
- HeadStart/Child Care Providers
- Maternal Child Health Programs
- Health Care Providers
- Child Advocacy Groups

Idaho has developed a multi-dimensional approach to outreach including but not limited to:

- Building on existing regional successes through emphasis on targeted, grass-roots outreach.
- State level coordination across all DHW Divisions. The state level has an internal project work team with representatives across DHW.
- Supporting regional efforts through a statewide public relations effort and professionally designed promotional materials
- Provision of technical assistance to regional efforts through outreach support teams
- Provision of funding to assist in implementing regional plans through community outreach grants. DHW has earmarked a minimum of $700,000 in TANF funds for community outreach. These funds were available to regions to help reach targeted groups defined in the regional plans. Regional planning teams solicited and selected applicants using the model RFP designed by the CHIP Performance Improvement Team.
- Using VISTA Volunteers. Regional Directors have requested two VISTA Volunteers per region. Funding for this project came from TANF and Americorps. VISTA workers will be used for CHIP community outreach and education efforts. This program is modeled after the nationally recognized Idaho VISTA immunization project

Regional activities are based on a regional plan. The plan was developed and implemented under the direction of the Regional Director with the assistance of Healthy Connection Staff. The Healthy Connections staff is part of the Division of Medicaid but located in regional offices. The staff has primary responsibility for Medicaid's Primary Care Case Management Program. The planning process brought interested stakeholders to the table to share ideas and enhance coordination of outreach/education/enrollment for CHIP throughout the region. The regional plan included at a minimum:

- Targeted groups for the region
- Message and approach for reaching each group including strategic outreach partners i.e. schools, HeadStart, WIC
- Potential partners to assist enrollees in completing applications i.e. hospitals, primary care clinics
- Priorities for community outreach grants
- Potential business partners and recruitment strategy to involve these partners
- Potential staff resources

The grassroots/regional activities are being supported by media activities. DHW has established a media contract to provide professional assistance in the design and implementation of the CHIP media campaign. Media activities include but are not limited to:

- A standard logo
- New posters in both Spanish and English
- Business cards in English on one side and Spanish on the other
- Television advertisements. The ads started in February 2000 with a rotating schedule over the next two years
- CHIP phone number in all Idaho telephone directories under government, business, and in yellow pages
- A Spanish language outreach component including Novellas on Spanish radio, Spanish print ads, and Spanish radio spots
- CHIP decals, stickers, buttons, and other collateral materials
- Radio ads targeted to mothers and fathers emphasizing working parents in the 21-34 age bracket

6. Eligibility determination process

In November 1999, Idaho's Department of Health and Welfare implemented a number of new eligibility determination processes designed to improve enrollment. These processes are as follows:

- Self-declaration of income and assets for Children's Health Insurance. These processes were changed:

✓ Simplification of the verification process so to not discourage parents from applying.
✓ Enhanced flexibility for the Self-Reliance workers in determining what is reasonable and prudent.

- Annualize income for enrollment. This policy was adopted to assist seasonal or temporary workers. In some cases, the bulk of a worker's income may be earned during a time-span of three to four months. This policy allowed the Department to average the income out over the year. (Note: After discussion with HCFA, this policy was repealed).

- Elimination of the requirement for proof of citizenship from non-applicants. This policy was adopted to comply with Federal law.

7. Eligibility redetermination process

The state established an ex-parte redetermination process at the beginning of FFY 2001. This step was taken to assure that:

- The State has explored and exhausted all possible avenues to eligibility before terminating Children's Health Insurance coverage.
- The participant is not required to provide information that is available through ex-parte contact.
- Families who remain eligible for coverage are allowed to plan for well child care and continue any necessary treatment plans without interruption.
- To simplify administration of the program.

8. Benefit structure NC

9. Cost-sharing policies NC

10. Crowd-out policies NC

11. Delivery system NC

12. Coordination with other programs (especially private insurance and Medicaid) NC

13. Screen and enroll process NC

14. Application

As part of its efforts to significantly increase enrollment of eligible children, DHW under the direction of Karl Kurtz undertook a fast-track redesign of the Application for Assistance. The redesigned form is four pages long and is used for all benefit programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home). See Attachment 2.

15. Other

The State has begun a Resource Utilization Study to analyze the work processes within the field and central office staff for the Self-Reliance programs. The purpose and scope are to:

- Determine the impacts of welfare reform implementation and determine how resources are currently used.
- Develop a comprehensive and sustainable resource allocation model for the Self-Reliance program.
- Provide general information for analyzing staff activities and time allocations.

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

Idaho has made significant progress in increasing the number of children with creditable health coverage, exceeding its target of 8,000 new enrollees by 150 percent. With a ceiling of 150 percent of the federal poverty level on the Idaho CHIP program, most of the children enrolled in the last year have been enrolled in the Title XIX Program, especially the Pregnant Women and Children Program. **The Department of Health and Welfare has increased enrollment by 21,252 children in Title XIX and Title XXI programs.** Over the last six months, Idaho has enrolled an average of 1,700 children per month in the combined programs.

Idaho CHIP Enrollees FFY 2000

	10/1/99	9/30/00	Increase	% Increase
Title XXI SCHIP enrollees	3,735	7,803	4,068	109%
Title XIX Medicaid enrollees	51,089	68,273	17,184	34%
Total	54,824	76,076	21,252	39%

The data for the number of enrolled children comes from the Divisions of Welfare and Medicaid in the Idaho Department of Health and Welfare. It is derived from actual caseload data in the Division of Welfare and actual counts of eligible children in the Division of Medicaid and comes from the automated information systems in those Divisions.

In September 1999, using data from the most recent CPS survey, the Department had estimated that there were 35,000 uninsured children at or below the 150 percent poverty level and that 8,701 of them would be eligible for SCHIP. As discussed in the response to question 4, Idaho believes that the estimates of uninsured children have been significantly below what actual enrollment experience has been. Idaho does not now have accurate data on either the number or rate of uninsured children for FFY 00.

Idaho's CHIP has made a major dent in the number of uninsured children. However, a simple subtraction of enrollees from last year's estimate of the total uninsured children would be a major error. There is still considerable work to do to reach the thousands of children still uninsured.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As indicated above, 17,184 children have been enrolled in Medicaid as a result of the SCHIP enrollment effort. For every five new enrollees, four enroll in Medicaid and one in SCHIP. CHIP has been a successful instrument to enroll children who may have been eligible for years but were not enrolled.

The data for the number of enrolled children comes from the Divisions of Welfare and Medicaid in the Idaho Department of Health and Welfare. It is derived from actual caseload data in the Division of Welfare and actual counts of eligible children in the Division of Medicaid and comes from the automated information systems in those Divisions.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Governor Kempthorne and the Idaho Legislature worked with the insurance industry to create a high-risk pool and provide financial relief to maintain Idaho's current methods of making individual plans available. The Legislature's Insurance Premium Task Force has continued to work through the year exploring options to reduce the rate of uninsurance in Idaho, which grew in 1999 to 17.7% of the population.

The Boise Chamber of Commerce, in conjunction with Saint Alphonsus Regional Medical Center, has explored options to assist small business owners in making insurance more affordable for them and their employees. In conjunction with this group, the Idaho Department of Commerce has submitted a proposal to HRSA to fund a study of the uninsured in Idaho and develop policy proposal to cover all uninsured.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

    ____ No, skip to 1.3

    _X_ Yes, what is the new baseline?

During the fall of 2000, the Idaho CHIP project team undertook an analysis of the number of uninsured children in Idaho in order to determine if there was a process for developing baseline projections, which would more closely reflect our actual experience in enrolling children. This analysis is contained in Attachment 3.

Because of the variability in estimates around the number of uninsured children in Idaho, the Idaho Department of Health and Welfare has developed a range for the baseline of potential enrollees in the CHIP program. The low end of the range is the approximate figure of an additional 40,000 uninsured children living in households below 150% of the poverty level. Data from the American Academy of Pediatrics for 1999 estimates 72,000 uninsured children in Idaho regardless of income. This figure represents the high end of the range. Using the 40,000 as the low end of the range and the 72,000 as the upper end, the projection group

established the midpoint at approximately 55,000 to 60,000 uninsured children. The estimating group feels that most uninsured children in Idaho would be under 200% of poverty and a large number could meet the current Medicaid eligibility requirements. **Thus, there may be as many as 72,000 uninsured children in Idaho, of whom more than three-fourths may live at 150% of poverty and below.**

What are the data source(s) and methodology used to make this estimate?

The following data sources (s) were used to make this estimate:

- The Idaho Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Bureau of Vital Records and Health Statistics, Division of Health in cooperation with the Centers for Disease Control
- The Census Bureau Current Population Survey (CPS)
- Other data sources such as the American Academy of Pediatrics and the Annie E. Casey Foundation Kids Count Databook

The Department created an estimating group of individuals knowledgeable about health care statistics in Idaho including Department statisticians and academics to develop a consensus estimate based on a review of all available data and a "best" judgment assessment process.

What was the justification for adopting a different methodology?

This methodology was a direct outgrowth of the Department's concern that best available estimates at the time the CHIP program was launched did not adequately capture the potential Idaho CHIP program given the geometrical growth of the program in one year's time. In addition, a review of available estimates suggested extreme variability between the various projections.

What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Idaho has not undertaken a specific review of the number of uninsured children in the state. This is further complicated in the case of CHIP because of the income eligibility of the children. The data from which extrapolations are made have the following limitations:

- The Behavioral Risk Factor Surveillance System (BRFSS) collects health data for adults and has some data limitations. In general, the data are self -reported. There is some sampling error. The sample is made up of adults with telephones who are English speaking, non-institutionalized, and living in households. Specific to estimating the CHIP population, income is reported as household income in total and as a range, not a specific figure. Poverty levels are based upon midpoints of the reported income ranges. The BRFSS is designed to provide estimates for the adult population and not estimates for the child population. Households with children are a subpopulation of the sample. The overall consequence of these data limitations is that it is possible that populations at risk of being uninsured are undercounted. The BRFSS estimates that in 1999, the midpoint of uninsured Idahoans at or below 150% FPG is 22% with a lower bound (95% CI) of 17% and an upper bound

of 26%.

- The Census Bureau Current Population Survey (CPS) requires that people be without insurance for the full year prior to being counted as uninsured. The CPS, conducted monthly since 1940, is the source of official Government statistics on employment and provides current estimates on the economic status and activities of the population of the United States. A secondary purpose of the survey is to collect information (age, sex, race, marital status, educational attainment, and family structure) on the demographic status of the population, and on additional questions such as health, education, income, and previous work experience. The statistics resulting from these questions serve to update similar information collected once every 10 years through the decennial census. **Please Note:** Estimates of the uninsured, which require respondents to have been without insurance for a period of time, are uniformly lower than estimates, which use a point in time methodology. For purposes of determining whether children have other creditable insurance, the Idaho CHIP program makes a point-in-time determination on the date the application is submitted.

- The U.S. Census Bureau's Current Population Survey (CPS) is more current than other national data sources and uses a large sample size designed to produce credible state-level estimates. Therefore, CPS data is widely cited and used as the basis for estimates produced by other organizations, including the American Academy of Pediatrics and the Annie E. Casey Foundation Kids Count Databook. The U.S. Census Bureau's Current Population Survey estimates that in 1999 there were 386,000 children in Idaho. A review of these projections for Idaho demonstrates the problem of estimating the potential population for the CHIP program. The American Academy of Pediatrics and the Annie E. Casey Foundation have the used the same base number and published different estimates. The Casey Foundation estimates there are 60,000 uninsured children in Idaho while the American Academy of Pediatrics puts the number at 72,000.

- Idaho has experienced very rapid population growth which further reduces the accuracy of dated extrapolations of data
- Idaho has experience substantial growth in the number of low-income individuals in the state at a time when other states are experiencing a lessening of this trend. This means that more and more people may become eligible at any point in time.

The Behavioral Risk Factor Surveillance System (BRFSS) conducted by the Bureau of Vital Records and Health Statistics, Division of Health in cooperation with the Centers for Disease Control has a confidence interval of $\pm$ .05 percent. Unfortunately, as noted above we are not exactly sure how the BRFSS methodology relates to CHIP children because of differences in assessing income of survey participants and CHIP eligible children.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

During the period covered by this annual report (October 1, 1999 to September 30, 2000), the number of

children enrolled in the combined Idaho Medicaid (Title XIX) and Idaho CHIP (Title XXI) rose from 54,824 to 76, 076 for a total enrollment increase of 21,252. This enrollment growth passed both our fiscal year 2000 and 2001 goals as outlined in our state plan and is close to our 2002 target.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3*.

Table 1.3 is enclosed as Attachment A.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Idaho has achieved or exceeded its performance goals related to outreach, enrollment, process simplification, and community involvement. While Idaho achieved its goal of enrolling children in Healthy Connections, it is concerned that overall enrollment in Healthy Connections is decreasing and access to care is becoming an issue. This issue is being addressed by the Department of Health and Welfare and its CHIP Quality Improvement Committee and an action plan is in the process of development.

Due to data limitations, Idaho is not clear on how well it is achieving its goals related to immunization and preventive care. Work is in progress to refine the data in both areas in order to track progress, with the hope that this quality information will become available in FFY 01.

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

NA

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The Department has made performance monitoring and evaluation an integral part of the CHIP implementation process. The Department is undertaking the following activities as part of its ongoing efforts to monitor performance:

- Conduct a review of a sample of CHIP applications from the last three months to compare income used to determine eligibility against total household income for both approvals and denials. This approach is designed to generate a percentage that could be applied to the total uninsured population to get at a more accurate CHIP-eligible number. This review should be completed by February 2001.
- Develop a series of work groups to assist the Department in developing an approach to more accurately monitor access to care. Current data is based on extrapolations of data that does not have a high degree of reliability in Idaho's rapidly changing economic context.
- Undertake ongoing program integrity reviews to assure that new eligibility rules are appropriately and accurately applied.
- Refine existing data to monitor achievement of quality outcomes related to immunization and preventive care. This data should be available Fall 2001.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

List of Attachments

A	Table 1.3
1	Outreach Plans and Education
2	Application for Assistance
3	Uninsured Study
4	Customer Satisfaction Study
5a	Enrollment/Target Chart
5b	Enrollment/Target Chart
6	New Renewal Procedure
7	Summary of Customer & Staff
8	CHIP Brochure

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

3. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

   Definition: Crowd out is defined as the substitution of enrollment in CHIP for a child's enrollment in a group health plan or other creditable health insurance as defined by HIPAA.

2. How do you monitor and measure whether crowd-out is occurring?

   Monitoring: Due to the low-income cap on program eligibility, Idaho has not formally monitored crowd out. Medicaid/CHIP administration has not received any substantial anecdotal information that would indicate that crowd out is a problem in Idaho. Information on insurance coverage is asked on the application. Those with creditable health insurance but who are otherwise CHIP eligible are not enrolled.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Results: See above.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Anti-crowd out policies: The Idaho Legislature and CHIP Task Force were both very concerned about families dropping their health insurance to enroll their children in CHIP. The Legislature in 1998 set the upper income limit for CHIP at 150 percent of the Federal poverty level and reaffirmed that level in its 2000 session. The result of that level is that crowd out has been an insignificant issue in Idaho.

During the enrollment process, questions are asked about the child's participation in other health insurance program as a means of assuring that children with health insurance are not enrolled. Idaho's experience to date is that very few children have insurance at the time of application, which is why their parents are applying for them.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The state has found a combination of activities effective in reaching low-income, uninsured children. Overall, the structure of the outreach/education plan has been for central office to improve awareness with the general public and to support regional grassroots efforts. This complementary approach to outreach and education has utilized resources effectively and provided communities with the knowledge and tools to conduct outreach. The following activities are examples of the type of outreach conducted at the central office level and at the community level.

Idaho CHIP Outreach Activities Summary Table

Activity	Central Office	Community Based
Develop and distribute educational materials i.e. brochures, posters, newsletter articles, website, misc. collateral materials	✔	
Develop training for families and organizations that work with families and children	✔	
Give CHIP educational presentations to families and organizations that work with families and children	✔	✔
Develop and implement media campaigns	✔	
Develop and support outreach/education contracts with community partners	✔	✔
Attend health fairs & community events	✔	✔
Coordinate CHIP activities with community partners		✔
Provide CHIP information to health care providers i.e. professional conferences, presentations, materials distribution	✔	✔
Develop, manage, and evaluate CHIP/VISTA (Volunteers in Service to America) Project	✔	
Provide technical assistance to communities	✔	
Provide feedback to Central Office		✔

Outreach effectiveness is being measured through enrollment and telephone calls to the resource and referral program, the Idaho Care Line. The combination of outreach and simplification efforts has resulted in an increase of approximately 1,700 children per month in either the Title XIX or Title XXI programs over the past six months. The total number of calls about CHIP to the Care Line from September 1999 to September 2000 has been 44 percent of the total volume of calls into the Care Line. Outreach conducted through community contracts is being evaluated through monitoring of the scope of work. Currently, the majority of contracts are in their first quarters and have not submitted reports.

Below are the highest referral methods documented by the Care Line in descending order from the highest to the lowest:

- **Television**

- **Radio**
- **School contacts**
- **Family or friends**
- **Medical professional**
- **Other**
- **Other Idaho Department of Health and Welfare Programs**
- **Brochures/flyers**
- **Newspaper**
- **Phonebook/information**
- **Post Office**
- **On-line**

Care Line activity greatly increased in conjunction with major efforts including the television and radio campaigns and in September when over 400,000 CHIP flyers were sent home in back-to-school packets to children and adolescents in approximately 92 percent of all Idaho public and private schools.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

CHIP outreach projects targeted to historically difficult to reach populations such as Hispanics, rural, low-income, and adolescents-at-risk are in their first quarter of implementation. Outreach and education efforts focused on the populations identified above are being conducted at a grassroots level by agencies and organizations that have established trusting relationships with the families. The following list identifies the community organizations and agencies the Idaho Department of Health and Welfare has contracted with to conduct outreach. The Department will evaluate the outreach as more information and data from the contracts are submitted.

Community Outreach Contracts List
▪ 3 Indian Health Centers
▪ 3 Head Start Programs
▪ 19 Local School Districts
▪ Child Care Connections
▪ Community Action Agency
▪ Bannock Youth Foundation
▪ 2 Federally Qualified Health Centers
▪ Idaho Migrant Council
▪ Idaho State University Department of Family Medicine and Institute of Rural Health
▪ Girl Scouts of America
▪ Idaho Legal Aid Services
▪ LaPosada
▪ Women and Children's Alliance (WCA)
▪ 7 District Health Departments

3. Which methods best reached which populations? How have you measured effectiveness?

As noted above, the Department is in the process of evaluating outreach targeted to hard to reach populations.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

To ensure that eligible children stay enrolled in Medicaid and CHIP the State has implemented a 12-month continuous eligibility process and an ex-parte redetermination process.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
_X_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population _____
___ Information campaigns
_X_ Simplification of re-enrollment process, please describe _1.1.7_____
___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
___ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

YES

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The 12-month continuous eligibility process is the most effective measure in ensuring that eligible children stay enrolled in Children's Health Insurance.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The Department does not have data regarding insurance coverage of those whose disenroll or do not reenroll in CHIP.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

One of the successes of the Idaho Program has been the decision to operate the program as an expanded Medicaid program. This decision made the eligibility lines between the Title XIX program and the Title XXI program invisible for program participants.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

NA

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

YES

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

2.8 Assessment and Monitoring of Quality of Care:

Idaho has created a CHIP Quality Improvement Committee comprised of Departmental and community representatives. Community members include representative of Head Start, the Hispanic Commission, the Robert Wood Johnson Covering Kids Project, the Idaho Hospital Association, the Idaho Academy of Pediatrics, field staff, and District Health Departments. This committee met twice in this fiscal year to track the progress Idaho is making in achieving quality outcomes for enrolled children and to provide ideas for program improvement. This group is assisting in the design and monitoring of quality of care objectives.

At this time, the primary issued before the group is access to care. It has asked for a study of access issues to determine levels of severity of the problem by provider group. This information will assist the Department of Health and Welfare in the development of methods to ensure that enrolled children have adequate access to care.

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Quality of care information: Little accurate information is available on the quality of care received by

SCHIP enrollees. Idaho has targeted immunizations and preventive care for children less than one year as its first two quality objectives. Good immunization data is still pending. Idaho is developing a central immunization registry, but that will not be available until summer 2001. Preventive care data must come from the claims payment system and is dependent upon proper coding of procedures.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   Monitoring processes: Idaho is developing monitoring processes (immunization registry and claims data) for immunizations and preventive care. In other areas, nothing has yet been developed due to system limitations. At this point, Idaho can track the number of Medicaid/CHIP children receiving primary, vision, behavioral, and dental care when Medicaid reimburses those services.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

   Future monitoring plans: Idaho is developing refinements to its Medicaid information system and working on an enterprise information system. In both areas, quality of care indicators will be identified and built into the system. However, information from these new systems may not be available until FFY 02 or 03.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility

Program eligibility/ successes:
In November 1999, DHW implemented a number of successful new policies designed to improve enrollment. These policies are as follows:

- Establishment of a 12-month continuous eligibility period for children.
- Self-declaration of income and assets for health coverage for families and children.
- Align the income projection method with the income methodologies used for other benefit programs.
- Elimination of the requirement for proof of citizenship from non-applicants.

Program eligibility/ barriers:
- Annualize income for enrollment. This policy was adopted to assist seasonal or temporary workers. In some cases, the bulk of a worker's income may be earned during a time-span of three to four months. Unfortunately, this methodology was more restrictive than 1913 and was not approved by HCFA in the State plan. It was not approved because an applicant's eligibility must be determined based on the applicant's circumstances in the month of application, not historical or future income.

2. Outreach

The following are outreach successes and barriers the program has encountered.

Building Partnerships: Building partnerships both internally and externally with organizations and agencies that work with children and families has been instrumental in outreach efforts. With limited resources dedicated to CHIP, partners have contributed to the success of the program by educating the families they work with about the program. These partnerships have also been successful in helping to identify program strengths and weaknesses. For example, a Community and Migrant Health Center informed us the material the Department developed addressing public charge was confusing. The Department followed-up by gathering representatives from the Hispanic community to develop and distribute new public charge materials and training.

Internal Communication: Communicating within the Department across Divisions and geographic boundaries has been a challenge. At the beginning of CHIP there was not a systematic distribution or reference person to help distribute information. This past year, the Department has addressed this challenge by: forming a multi-division oversight committee, creating positions for a CHIP manager and CHIP trainer, allocating .5 FTE staff per region as CHIP Coordinators, quarterly CHIP training, and bi-monthly CHIP coordinator conference calls. The CHIP manager has headed up site visits to all regions, satellite conferences, inclusion of CHIP information in the weekly Department staff web based news, and has participated in multi-division work teams.

Media: Television and radio ads have been successful in greatly increasing the volume of calls into the Idaho Care Line. Television was run in the winter months and radio was implemented during the summer months when most people are busy outside the home.

Community Based Outreach Efforts: Basing outreach strategies within the community while supporting it at a central level with media, education pieces, and technical assistance has helped to improve relationships within communities and build trust among applicants and participants. Idaho's delivery system is organized regionally and having all outreach efforts based in Boise would not have been successful. It has been important to build and support relationships within communities.

School Efforts: Working with schools has been both successful and challenging. The State Department of Education has supported CHIP through endorsement by the State Superintendent and by placing articles in their newsletters to educators. However, outreach activities must be negotiated at the school district level. With over 100 school districts, statewide, this has proved to be time consuming and a strain on regional resources.

3. Enrollment

Enrollment Process/Successes:

- **Shortened Application**. Idaho's application was shortened from 17 pages to four pages. It has greatly simplified the process of applying for benefits, which is reflected in our increased enrollment numbers. The feedback on the application from participants, community partners and stakeholders and from staff is very positive. It has become a model for other states' in their efforts to simplify their application forms.
- **Accept Mail-in Applications**. Idaho eliminated the requirement for a face-to-face interview for applicants for the Children's Health Insurance Program. Now mail-in applications are accepted with follow-up by telephone if necessary for further clarification.
- **Evaluation of Enrollment Process**. Two methods were implemented to evaluate the success of the enrollment process.

✓ The first was survey cards attached to applications. These cards allow participants to comment on the service they received. The data from these cards is compiled monthly and reported to executive level management in the Executive Information Management Report.

✓ The second was participant focus groups where participants are asked what they see as working to make access to services easier and also what they see as barriers to service.

Enrollment Process/Barriers:

- **Cultural Shift**. The cultural shift within the Department of Health and Welfare for the simplified enrollment process for Children's Health Insurance has been more difficult because these processes do not align with the enrollment processes for the other programs, such as the Food Stamp, Child Care and TANF program. Many of the innovations in this program will only be sustainable, if the other programs are also simplified. To address this issue, a Simplified Access to Services Project has been implemented with an objective of aligning policies and procedures across programs.

4. Retention/disenrollment

Retention/Disenrollment/ Successes:
Two successful policies have been implemented to increase the Children's Health Insurance retention/disenrollment rates. These policies include:

- Establishment of a 12-month continuous eligibility period for children. This policy is easy to administer, serves families and health care providers by allowing them to plan for and follow-up with well child health care and ongoing treatment plans, and is appreciated by staff, parents and other stakeholders.
- Simplified redetermination or renewal process. The state established an ex-parte redetermination process at the beginning of FFY 2001. It appears to be a success and more details will be included in the Annual Report for FFY 2001.

5. Benefit structure NA

6. Cost-sharing NA

7. Delivery systems NA

8. Coordination with other programs

CHIP is a Medicaid expansion in Idaho. The CHIP and the Family Medicaid programs are being marketed as one program. If a child's family income is less than 150 percent of the Federal poverty limit and the family meets the asset test, that child is eligible for the Children's Health Insurance Program. The Medicaid or CHIP coverage group is invisible to the participant.

This has done a great deal to eliminate the stigma of "Medicaid" for families. The result is the dramatic increase in enrollment for Idaho's children. The positive features of this choice are as follows:

- Outreach could be for the single Idaho Children's Health Insurance Program rather than for a Medicaid program and the separate CHIP program

- Children do not disenroll because of problems in transferring eligibility between the two programs since the eligibly rules are the same.

- The program is easy for the public to understand leading to broader public and political support.

- It is more cost effective both in terms of media activities as noted in outreach above and in terms of ease of administration. Eligibility workers only need to learn one set of rules.

- While access is a problem in Idaho, we believe the combined program enhances access by facilitating provider participation in one program through ease of understanding one set of rules and billing procedures.

9. Crowd-out

10. Other

A) Public Charge/success. Idaho has completed an education process on public charge. This process is designed to assure people that applying for and receiving Children's Health Insurance will not be a barrier to their applications for citizenship or naturalization. The training is accomplished through:

- Posters and brochures in DHW offices and all outreach locations.
- A training packet given to all individuals involved in the outreach process and to the Self Reliance staff.

B) Public Charge/barriers.

While the Idaho program has experienced tremendous overall success, the future holds a number of barriers to delivering quality health services to children. These barriers are as follows:

a) INS Barrier

Idaho has a significant Hispanic population, many of whom would probably be eligible for CHIP. It has come to the attention of the Department that Immigration and Naturalization officials in Idaho have suggested that to individuals that applying for CHIP status may hurt that current status in the United Status. The Department is undertaking efforts to meet with INS and attempt to correct any inaccuracies in this area. We have requested assistance from officials in Region X with this process.

b) Data Barrier

As noted in other sections of the report, the Department is hampered by its lack of data about the potential pool of CHIP eligible children. We believe the best approach would be to contact for a child specific survey that would capture a more accurate picture of children's insurance and health status would cost between $300,000 and $400,000. It is our understanding that this is an area with which other states are struggling. If this is the case, we would recommend that HCFA consider providing incentive grants to states to undertake additional analysis of the population in need of CHIP services.

c) Access Barrier

Federal Health Professional Shortage Area (HPSA) data indicates that many parts of Idaho are designated as rural or frontier regions in terms of availability of health providers. In areas with adequate providers there is a problem with providers accepting new Medicaid patients because of the provider fees paid by Medicaid and ability to have a full practice without Medicaid clients. Initial reviews by the Department indicate that this problem is most prevalent in the areas of primary care, behavioral health and dentistry. CHIP project team members working on the issue have access have found the problem is difficult to capture because of data limitations. Current issues of access will be further compounded as the numbers of children enrolled in the Idaho CHIP program increase. The Department has established a workgroup to undertake an initial study of this issue. The findings of this group were presented to the CHIP Executive Oversight and Quality Assurance Committee in December 2000. Several action task forces to address each access area will be created in Spring 2001 to develop recommendations on how to improve access in Idaho.

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles			
Fee for Service	$8,527,344	$16,470,000	$23,792,000
Total Benefit Costs	$8,527,344	$16,470,000	$23,792,000
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$8,527,344	$16,470,000	$23,792,000
Administration Costs			
Personnel	$120,098	$232,055	$335,275
General administration	$980,751	$1.797,688	$2,597,316
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	$216,481	$418,090	$604,060
Other			
Total Administration Costs	$1,267,330	$2,447,833	$3,536,651
10% Administrative Cost Ceiling	$947,483	$1,830,000	$2,644,000
Federal Share (multiplied by enhanced FMAP rate)	$7,495,536	$14,553,990	$21,072,136
State Share	$1,979,291	$3,746,010	$5,363,864
TOTAL PROGRAM COSTS	**$9,474,827**	**$18,300,000**	**$26,436,000**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

NA

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

Idaho has submitted a state plan amendment that would use funds from the Idaho Robert Wood Johnson Foundation Covering Kids grantee, the Mountain States Group, to assist with outreach activities. Funds from that source would be used pending approval from HCFA.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	CHIP (Children's Health Insurance Program)	
Provides presumptive eligibility for children	__X__ No _____ Yes, for whom and how long?	_____ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No **Children; three months prior to application.** __X__ Yes, for whom and how long?	_____ No _____ Yes, for whom and how long?
Makes eligibility determination	__X__ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____	_____ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)* _____
Average length of stay on program	Specify months __9 months__	Specify months _____
Has joint application for Medicaid and SCHIP	_____ No __X__ Yes	_____ No _____ Yes
Has a mail-in application	_____ No __X__ Yes	_____ No _____ Yes
Can apply for program over phone	__X__ No _____ Yes	_____ No _____ Yes
Can apply for program over internet	__X__ No _____ Yes	_____ No _____ Yes
Requires face-to-face interview during initial application	__X__ No _____ Yes	_____ No _____ Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Requires child to be uninsured for a minimum amount of time prior to enrollment	___X__ No _____ Yes, specify number of months _____ What exemptions do you provide?	_____ No _____ Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____ No ___X_ Yes, specify number of months ___12_____ Explain circumstances when a child would lose eligibility during the time period: Requested by family, move out of state, or death.	_____ No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	___X__ No _____ Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____ No _____ Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	___X__ No _____ Yes	_____ No _____ Yes
Provides preprinted redetermination process	_____ No ___X__ Yes, we send out form to family with their information precompleted and: _X ask for a signed, verbal or electronic confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination process differs from the initial application process in the following ways:

- A new Application for Assistance is not required, instead the participant's situation is re-evaluated and documented through recent contact, phone conversations, or the participant completes a one-page form and returns it to the Department by mail or e-mail.
- Ex-parte contact is considered sufficient verification for the renewal process.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	133% of FPL for children under age six 100% of FPL for children aged 6 through 17 ____% of FPL for children aged _____
Medicaid SCHIP Expansion	150% of FPL for children up to age 19 ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$90 + $30 & 1/3	$0	**N/A**
Self-employment expenses	Actual costs of doing business	$0	**N/A**
Alimony payments Received	$0	$0	**N/A**
Paid	$0	$0	**N/A**
Child support payments Received	$50	$0	**N/A**
Paid	$0	$0	**N/A**
Child care expenses	? Actual costs up to $200 for children under age two. ? Actual costs up to $175 for children over age two.	$0	**N/A**
Medical care expenses	$0	$0	**N/A**
Gifts	$30 per quarter	$0	**N/A**
Other types of disregards/deductions (specify)	$ 100 of TANF payments for one and two person	$0	**N/A**

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
	families		

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	____No	X	Yes, specify countable or allowable level of asset test $5,000
Medicaid SCHIP Expansion program	____No	X	Yes, specify countable or allowable level of asset test $5,000
State-Designed SCHIP program	NA		
Other SCHIP program	NA		

6.4 Have any of the eligibility rules changed since September 30, 2000? X Yes ___ No

Previously, income received in the last four months was averaged and the average amount was counted.

Effective 11/01/00, income received in the month of application is counted for Medicaid and SCHIP eligibility.
Income is now annualized for self-employed people or seasonal farm workers only, if needed to make the family eligible.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage

2. Employer sponsored insurance buy-in

3. 1115 waiver

4. Eligibility including presumptive and continuous eligibility

5. Outreach

6. Enrollment/redetermination process

As part of the Department's ongoing quality assurance and monitoring process, each element of the Idaho CHIP program is evaluated as it is implemented. Based on this ongoing evaluation the Department is in the process of refining its four page Application for Assistance. These refinements have taken the form of focus groups with the field, clients, and stakeholders. In addition, the Department has undertaken a series of work groups composed of workers and stakeholders. Proposed revisions were put out for comment in December with an implementation date of a refined application by March 1, 2001. It should be noted that as part of this process, the Department established strict parameters that the length and style of the current application must be honored but that wording and layout changes to simplify the document for workers and/or clients based on usage should be implement.

The Department also implemented a streamlined redetermination process (entitled Renewal Process to emphasis the customer/insurance focus) on October 1, 2000. The Department will be undertaking a thorough review of the implementation process similar to the one used for the application process.

7. Contracting

8. Other